TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
ALEGIS REVENUE GROUP

Respondent Name
TEXAS MUTUAL INSURANCE COMPANY

MFDR Tracking Number
M4-16-0115-01

Carrier's Austin Representative
Box Number 54

MFDR Date Received
September 14, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "While the DWC rule does not have a 'prudent layperson' standard, it is still — inevitably — largely a claimant's perception of severity that prompts him/her to seek emergency care. In the present matter, the Claimant was suffering from a recent onset of SEE MEDICAL RECORDS. It is reasonable to assume that this led the Claimant to believe that a delay in treatment would put him at risk of 'serious dysfunction of any body organ or part.'"

Amount in Dispute: $454.06

RESPONDENT'S POSITION SUMMAR

Respondent's Position Summary: "the documentation of the treatment failed to substantiate an emergency as defined by Rule 133.2(a)(4)(A)."

Response Submitted by: Texas Mutual Insurance Company

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
November 20, 2014	Outpatient Hospital Services	$454.06	$454.06

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.403 sets out the acute care hospital fee guideline for outpatient services.
3. 28 Texas Administrative Code §133.2 defines words and terms related to medical billing.
4. Texas Labor Code §408.021 establishes an injured employee's entitlement to medical benefits.

5. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 899 – DOCUMENTATION AND FILE REVIEW DOES NOT SUPPORT AN EMERGENCY IN ACCORDANCE WITH RULE 133.2
   - P12 – WORKERS' COMPENSATION JURISDICTIONAL FEE SCHEDULE ADJUSTMENT
   - W3 – IN ACCORDANCE WITH TDI-DWC RULE 134.804, THIS BILL HAS BEEN IDENTIFIED AS A REQUEST FOR RECONSIDERATION OR APPEAL.
   - 18 – EXACT DUPLICATE CLAIM/SERVICE
   - 350 – IN ACCORDANCE WITH TDI-DWC RULE 134.804, THIS BILL HAS BEEN IDENTIFIED AS A REQUEST FOR RECONSIDERATION OR APPEAL.
   - 736 – DUPLICATE APPEAL. NETWORK CONTRACT APPLIED BY TEXAS STAR NETWORK. CALL 800-381-8067 FOR RECONSIDERATION DISCUSSION
   - 899 – DOCUMENTATION AND FILE REVIEW DOES NOT SUPPORT AN EMERGENCY IN ACCORDANCE WITH RULE 133.2
   - 193 – ORIGINAL PAYMENT DECISION IS BEING MAINTAINED. UPON REVIEW, IT WAS DETERMINED THAT THIS CLAIM WAS PROCESSED PROPERLY.
   - 724 – NO ADDITIONAL PAYMENT AFTER A RECONSIDERATION OF SERVICES. FOR INFORMATION CALL 1-800-937-6824

Issues

1. Are the insurance carrier's denial reasons supported?
2. Does the documentation support an emergency?
3. Are the disputed services subject to a contractual agreement between the parties to this dispute?
4. What is the applicable rule for determining reimbursement for the disputed services?
5. What is the recommended payment amount for the services in dispute?
6. Is the requestor entitled to additional reimbursement?

Findings

1. The insurance carrier denied the disputed service(s) with claim adjustment reason code:
   - 899 – "DOCUMENTATION AND FILE REVIEW DOES NOT SUPPORT AN EMERGENCY IN ACCORDANCE WITH RULE 133.2."

   This denial reason does not, in and of itself, preclude payment; the Texas Workers' Compensation Act, at Labor Code Section 408.021 provides that "an employee who sustains a compensable injury is entitled to all health care reasonably required by the nature of the injury as and when needed." The entitlement is not limited to emergency care, and an emergency is not a prerequisite for payment of treatment for a covered injury.

   While medical emergency may be an *exception* to certain other denial reasons, the insurance carrier has not raised any of those on the EOBs. Discussing an exception does not raise a material defense by implication. The division finds the respondent has not presented any such defenses to the health care provider—and may not do so now.

   Review of the submitted information finds no explanations of benefits with denial reasons supporting an independent basis for denying payment to which the requirement of an emergency would be an exception.

   Rule §133.307(d)(2)(F) requires that:

   > The response shall address only those denial reasons presented to the requestor prior to the date the request for MFDR was filed with the division and the other party. Any new denial reasons or defenses raised shall not be considered in the review.

   The insurance carrier's failure to assert on the explanations of benefits specific denial reasons or defenses relating to the services in dispute during the bill review process—before the request for MFDR—constitutes grounds for the division to find a *waiver* of any such new defenses at Medical Fee Dispute Resolution.

   The division finds the respondent has waived any new denial reasons or defenses not previously raised and is therefore limited to the EOB denial reasons and defenses presented to the requestor during the bill review process—prior to the date MFDR was requested—as listed above. Review of the insurance carrier's denial reasons finds that the respondent has not established an independent grounds for denying the bill—and specifically has not raised any defenses to which the existence of an emergency would be relevant as an exception. Consequently, the question of whether an emergency existed is not relevant to payment of this bill. The insurance carrier's denial reasons are thus not supported.

2. Nevertheless, review of the submitted documents finds the record actually does support a medical emergency.

   Rule §133.2(5)(A), defines a medical emergency as:

   > the sudden onset of a medical condition manifested by acute symptoms of sufficient severity, including severe pain, that the absence of immediate medical attention could reasonably be expected to result in:
   > (i) placing the patient's health or bodily functions in serious jeopardy, or
   > (ii) serious dysfunction of any body organ or part.

   The division notes this rule does not require the patient to actually *be* in jeopardy or *suffer* serious dysfunction. Rather, the patient must manifest acute *symptoms* of such severity (including severe pain) that the absence of immediate medical attention could *reasonably be expected* (prior to rendering services and without the benefit of hindsight) to result in serious jeopardy or dysfunction if treatment is not provided.

   The respondent argues that the physician record reports that the pain was "moderate" and "chronic" (as opposed to "severe" and "acute") at onset.

   However, while the Physician Record documents in the *history of present illness* that back pain is moderate and chronic, the chief complaint is noted rather as "vomiting X1 day" with lower back pain listed second. The symptom of "vomiting X1 day" is sufficiently acute to warrant immediate concern. The report further documents "the course/duration of symptoms is constant and worsening."

   Moreover, the Triage Note by the nurse who performed Primary Pain Assessment at triage—before the injured employee was seen by the physician—documents the "primary pain" as "10 = Worst possible pain." This symptom is sufficiently severe *by itself* to meet the requirements of the definition to the point that the medical provider could not in good conscience have turned the patient away without immediate attention.

   Review of the medical documentation finds multiple symptoms described—including vomiting and severe pain—which meet the requirements of the definition in Rule §133.2(5)(A) sufficient to support a medical emergency.

   The division concludes the respondent has failed to support denial of payment based on lack of emergency. The disputed service will therefore be reviewed for payment according to applicable division rules and fee guidelines.

3. Review of the submitted documentation finds no information to support that the disputed services are subject to a contractual agreement between the parties to this dispute.

4. This dispute regards outpatient hospital facility services with reimbursement subject to 28 Texas Administrative Code §134.403, which requires that the reimbursement calculation used for establishing the maximum allowable reimbursement (MAR) shall be the Medicare facility specific amount, including outlier payment amounts, determined by applying the most recently adopted and effective Medicare Outpatient Prospective Payment System (OPPS) reimbursement formula and factors as published annually in the Federal Register with minimal modifications as set forth in the rule.

   Per §134.403(f)(1), the sum of the Medicare facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by 200 percent, unless a facility or surgical implant provider requests separate reimbursement of implantables. Review of the submitted documentation finds that separate reimbursement for implantables was not requested.

5. Medicare's Outpatient Prospective Payment System (OPPS) assigns an Ambulatory Payment Classification (APC) for billed services based on procedure codes and supporting documentation. The APC determines the payment rate. Hospitals may be paid for more than one APC per encounter. Payment for ancillary items and services without procedure codes is packaged into the payment for the APC. The Centers for Medicare and Medicaid Services (CMS) publishes quarterly lists of APC rates in the OPPS final rules, available from www.cms.gov. Reimbursement for the disputed services is calculated as follows:

   - CPT 96372 has status indicator S denoting significant OPPS procedure, not subject to multiple-procedure reduction, paid by APC. This is assigned APC 0437. The Addendum A rate is $43.78. This amount multiplied by 60% yields an unadjusted labor-related amount of $26.27, which is multiplied by the facility wage index of 0.8074 for an adjusted labor amount of $21.21. The non-labor related portion is 40% of the APC rate, or $17.51. The sum of the labor and non-labor portions is $38.72, at 2 units is $77.44. The Medicare facility specific reimbursement of $77.44 is multiplied by 200% for a MAR of $154.88.

- CPT 99284 is assigned status indicator V denoting an emergency visit paid by APC. This is assigned APC 0615. The Addendum A rate is $293.71, multiplied by 60% yields an unadjusted labor-related amount of $176.23. This amount is multiplied by the facility wage index of 0.8074 for an adjusted labor amount of $142.29. The non-labor portion is 40% of the APC rate or $117.48. The sum of the labor and non-labor portions is $259.77. The Medicare facility specific reimbursement of $259.77 is multiplied by 200% for a MAR of $519.54.
- HCPCS codes J1100 and J1885 have status indicator N denoting packaged items and services with no separate APC payment; reimbursement is packaged with payment for other services.

6. The total allowable reimbursement for the services in dispute is $674.42. The amount previously paid by the insurance carrier is $0.00. The requestor is seeking additional reimbursement in the amount of $454.06. This amount is recommended.

Conclusion

In resolving disputes regarding the amount of payment due for health care determined to be medically necessary and appropriate for treatment of a compensable injury, the role of the division is to adjudicate the payment, given the relevant statutory provisions and division rules.

The Division would like to emphasize that the findings and decision in this dispute are based on the evidence presented by the requestor and respondent available at the time of review. Even though all the evidence was not discussed, it was considered.

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $454.06.

ORDER

Based on the submitted information, pursuant to Texas Labor Code Section 413.031 and 413.019 (if applicable), the division has determined the requestor is entitled to additional reimbursement for the disputed services. The division hereby ORDERS the respondent to remit to the requestor $454.06, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

Authorized Signature

	Grayson Richardson	April 7, 2017
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with Rule §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.